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ABSTRACT

Assessed is the functioning of the Metropolitan Child Advocacy Committee established by the Oregon State Children's Services Division to provide evaluative and arbitrative services for children who did not fit easily into the normal social service framework. Case studies of two disturbed children whose cases came before the committee are presented. Conclusions such as the following are said to be supported by the committee's experiences: (1) when 'no decline' options are enforced and backed by proper legal and fiscal sanctions, some vicious destructive discontinuities in child placement can be avoided; (2) system and institutional goals are often in conflict with those of implementing the least detrimental course for the child; and (3) unless the child is a party (usually through an attorney) to proceedings which involve him, his best interests may not be served. (GW)

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IS CHILD ADVOCACY FOR CHILDREN

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The term child advocacy enfolds many theoretical, clinical and administrative issues; it is both connotative and denotative. It has something for everyone, but protean-like it can mean little. To some it connotes a new approach for children who are unserved, unheard for and untreated. To others it denotes a new discipline. Out of frustration and dissatisfaction with the past and the present one assumes a new approach should be used; that new institutional constraints should be modified; and most of all that professional care of children should act collectively and with a single purpose.

In this paper we will describe the rationale and operation of a form of child advocacy at the level of the individual child. Two representative cases are described to illustrate the operation and outcomes. We will conclude with our understanding of the reasons for the successes and failures.

The welfare of children begins at home with their biological and psychological parents. It then extends to local institutions such as the church and local government. Functions and services formerly held in local control are now often assumed by a larger state. Thus

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a county court may have obligations without resources and the state provides services without the same sense of physical immediacy. The child is in between. This works well enough for most children, but for a large group no one is sufficiently responsible to delicately meet that pre-emptory demanding immediate physical need so characteristic of childhood and which crosses institutional and structural boundaries.

In Oregon, as in other states, our child care structure seriously fails many children and in this ultimately fails society too. In 1971 the Oregon Legislature attempted a remedy by establishing a single state agency to combine issues of the law, welfare, delinquency and treatment where they concern children. Quickly some children showed they fitted no where. Generally, these were children held in custodial care awaiting placement in treatment or rehabilitative facilities, but for some reason did not fit the usual guidelines. For example a foster child with diabetes and an impulse disorder; he was not disturbed enough for a state hospital, his physical illness was beyond an ordinary foster home and he could not be reared by an ordinary hospital. The agency with statutory authority, the Oregon State Children's Services Division (C. S. D.), did not operate residential treatment programs for children with severely handicapping emotional problems, but contracted this care to a group of private institutions and organizations, each with its own goals and conditions. This worked well enough for most, but some were always excluded since contracts did not have a "no decline" option, nor did they have resources to provide special care when needed.

To work through these individual impasses C.S.D. proposed that representatives of child caring professions provide mutually agreeable treatment plans and a strategy for the implementation of some few programs on a child by child basis. Thus the organization of a "Metropolitan Child Advocacy Committee" whose costs were paid for by C. S. D. to provide evaluative and arbitrative services.

The Child Psychiatry Service of the University of Oregon Medical School organized and administered the committee. Cases were referred by C.S.D. Committee membership included leaders in the state from child psychiatry, psychology, social work, representatives of the local residential institutions and of C.S.D. In addition some children were parties to the proceedings, they had legal representation; their interests were represented by a legal advocate - a court appointed attorney.

The committee conducted diagnostic evaluations and developed an ideal and, in addition, a workable or implementable treatment plan. Since these were always children for whom ordinary planning had failed to yield a result the final treatment plan was always the product of negotiation within the committee. Plans and recommendations were then forwarded to the sponsor, C.S.D., and a court when indicated.

We now will illustrate the details of the work of the committee by describing two typical cases; they also represent the two clearly different outcomes. Clearly the ability to assist a child's development was often determined by factors unrelated to the best interests of that child.

Case No. 1. George, born 1959.

January 18, 1973: George had been in detention for three months and spent the majority of the previous year there too. He lived in several foster homes between 1963 and 1965 after he was abandoned by his parents. From 1965 to 1970 (age 6 to 10) he was in a residential center; he ran from there, set fires and fought with the other children. Still running, he was in another aborted foster care from 1970 to 1971. Another residential placement in May, 1972 only lasted three months before they requested relief. No agency would accept liability for his care. All had the option of declining and the child had no recourse or appeal.

After a review and a new examination the Advocacy Committee made the following recommendations to C. S. D. This proposal contained the obvious first steps toward the bilateral commitments necessary for treatment.

1. That George be placed in a residential facility ("Twin Oaks") with a "no decline" commitment from them, and that the staff expect and firmly meet the expected testing. A "no decline" commitment from the staff was defined as a commitment to keep George in residence and treatment despite "bad" behavior.
2. The no decline commitment was to be supported with extra funds from C. S. D. to provide:
   a. staff for extra supervision and structure.
   b. special back-up services when needed.
   c. pre-placement work with George.

3. To emphasize continuity George was to remain in detention until he entered Twin Oaks rather than use an interim foster home.
4. Twin Oaks staff was to begin the treatment program with George while he was in detention.

In the committee a court appointed attorney accorded George party status, thus insuring representation. When the behavior and social professionals failed to reach consensus the attorney was prepared to institute necessary legal coercive actions for the protection of his client's rights.

By February 15 the C.S.D. had rejected the committee's recommendations. C.S.D. agreed to them in principle, but felt the budget was too high and arranged for George's placement in still another private residential facility - South Home. There the recommended treatment arrangement could be made within an existing contract and not require extra money. The committee was skeptical about the ability of South Home to fulfill a "no decline" commitment without the extra support, but agreed to hear their plan even though this represented another delay for a boy already too long in detention.

With this delay, and at the same February 15 meeting, the attorney for the child reported on the following legal actions initiated by him on behalf of the child. He took the legal position that lack of funds was not an excuse for misjustice; in this case failure to provide necessary and appropriate placement and treatment:

1. On February 7, at the attorney's request, the Court ordered the county to expend funds to provide treatment while in detention, under the supervision of a specific competent child psychiatrist.
2. He applied for a writ ordering state officials to act to insure that George receive appropriate treatment after leaving detention.

3. He obtained a temporary restraining order to prevent transfer to South Home or any other place pending a hearing on the application described in #2 above.

By February 22 the committee agreed to George's placement at South Home but only when they waived their usual conditions and requirements for admission; a child could not conform to these in an informed way.

1. Completion of a successful pre-placement visit.
2. Willingness to accept the program.

While South Home would not make an absolute "no decline" commitment, their program could tolerate frequent and repeated running away and would not discharge George for that reason alone.

With these arrangements George's attorney deferred to the recommendations of the whole committee and withdrew the court actions.

By late February George was transferred to South Home. The expected testing was continuous but only one runaway occurred; it was managed in cooperation with the county jail for an overnight; there was never doubt that he would eventually return to South Home after each test.

According to South Home George is "doing better than expected" but they feel the strain of the extra effort to maintain the structure and supervision. Although they now provide these services to him within their regular contract, the expense makes it impossible to accommodate more than one or two of these "special" cases.

Case No. 2, Harry, born 1960.

On May 17, 1973, the Metropolitan Child Advocacy Committee

met to consider a treatment plan for Harry, in an institution for the retarded since November, 1972.

Because of parental abuse and neglect he and his siblings were referred to C.S.D. in 1965 (age 5). Between 1965 and 1968 he was in three different foster homes. Each placement ended because of his destructive actions and the consequent need for constant supervision, attention and discipline were far beyond any foster home. In 1968 he lived at a residential center, East Home, for three months. He was then sent to the state institution for the retarded even though he was only slow, not retarded. Six months later he was returned to East Home because the institution for the retarded felt he (sic) "could not cope with the high degree of activity" in the cottage which they believed stimulated his destructive and hyperactive behavior. While at East Home he did well enough, but the educational program was too low for him. He was there until August, 1972 when it closed and he went into foster care again.

There were early frequent clear warnings of disturbance in this home. By November, 1972 he was returned to the state hospital after chasing another child with a knife and, on the same day, successfully burned the foster parents' barn.

Although the return to the state hospital was supposed to be temporary, and no one believed it appropriate, no other placement could now be found; all institutions "declined."

The evaluation done for the committee summarized Harry as modestly retarded and severely depressed. He was preoccupied with aggressive fantasies, but these were manageable enough in a

stable setting that understood his particular problem.

The committee recommended the following obvious minimum residential and treatment requirements:

1. A low level of stimulation.
2. Regular supervised activities.
3. Willingness to provide this until Harry reached adulthood.

The committee believed the hospital for the retarded could do all of this, but they declined since he could "manipulate" them and their relatively unsophisticated program. They also demurred believing their program was designed for children more retarded than he. And finally, they could not provide proper treatment for his most disabling condition; his depression and severe impulse disorder.

The committee repeated its recommendation that an optimum setting for Harry was one that is:

1. Secure and contained.
2. Where he could remain until he is 18 to 20 years old.
3. Capable of providing an intensive treatment program focusing on: development of his capacity for object relations, social training and work education.

As of March, 1974, Harry is still in the state hospital for the retarded. They use that awful phrase of "not seen as appropriate" by any program, nor would any create a program for him. He still lives with children who are severely retarded and institutionalized. His psychiatric disorder is managed by the structure of the institution and thus, he'll probably never leave. The staff is discouraged at his

institutionalization and their impotence. The hospital social service director has asked C. S. D. for alternatives. The juvenile court judge from Harry's county has also written to the director of the State Department of Human Resources asking why committee recommendations have not been followed.

In this situation, a consensus system, the professionals reached an impasse. Harry could not speak for himself and had no "advocate." He was not a party to the proceedings and was not represented by an attorney even though he is a ward of the court.

Developing a program for George was influenced by his legal representative and the legal actions taken to assure the least detrimental course for his overall development. Without a similar advocate Harry's placement remains inadequate and continuously damaging; his development is compromised or halted.

Since June, 1973 the Metropolitan Child Advocacy Committee has received no referrals. "Because of reorganization" the funds C. S. D. used to support the activities of the committee are no longer available.

We have described the development and operation of a "committee" designed to perform individual evaluations and develop specific plans for these children. This committee, the Metropolitan Child Advocacy Committee, was created to be the arena for evaluating the present state of affairs with regard to a particular child; for determining an ideal approach; and to provide an arena for the arbitration necessary to determine workable stable arrangements that in short protected the child's development and ultimately that of society as well.

We have demonstrated that when no decline options are enforced and backed by proper legal and fiscal sanctions some vicious destructive discontinuities in child placement and child development can be avoided. We have also demonstrated, through the case examples, how system and institutional goals are often in conflict with those of implementing a least detrimental course of a child's development. We again learned, no matter the intentions of the professional, that unless the child is a party to proceedings which involve him his best interests may not be served. In these cases it was the usual culturally and socially sanctioned advocate (the attorney); he was the child advocate.

The re-statement of an essential dilemma taught another lesson. Agencies, professionals and institutions tend to respond in the nature of "what they do." Only the child, or his advocate and his interpreter, can respond to "what is needed."

In our view, the successes were related to the formulation and implementation of a series of checks and controls and open multi-lateral cross-discipline discussions rather than operation from a single frame of reference. Only in this way can all the facets of a child's life be attended to. Yet, when caught in conflict between the state and its agencies, a child does need representation and recourse for appeal.

Some comments are in order by way of summary and conclusions.

First: We believe the outcome of our committee is analagous and similar to that of the community action programs of the 1960's, the War on Poverty. In part the community action programs were created to make institutions serving the poor more responsive to them. We

had to re-learn the sad lesson of those programs; a lesson taught in elementary sociology: Institutions exist to stabilize something found worthwhile in a culture of society. Because change generates conflict, it is a function of an institution to resist change. This committee was a change created to provide an arena in which to resolve these conflicts and protect the development of some children who did not fit the institutions. Instead, the committee, itself, died. To put it more simply, one cannot often be hired by an institution to change that very institution without jeopardy.

Second: No matter what the competency and motivation of the responsible adults, no matter how caring they are, nothing happens for the unusual child unless he has an advocate who is outside the immediate system of identifications, employments, dependencies and structures. The lawyer (the only culturally and socially sanctioned and trained advocate) provided that representation. Treatment plans were never implemented for those without that representation.

Third: We demonstrated that when representation was broad, the child a party to the negotiations, and the institutions could work without defensiveness, rational planning was accomplished and treatments initiated and sustained with minimal extra costs.

Finally: It is, of course, necessary to distinguish this "plan for an individual child" from the "individualized treatment planning" everyone does. Here we mean a plan that can maintain integrity in the face of institutional structures and pressures. Individual plans and individual advocacy are as important as an institutional capacity

for individualized responses. For most children the present mix of program and structure is perhaps satisfactory, but for some special cases a plan for the individual child and an advocate to carry that plan forward is the only one that avoids disaster and provides the least detrimental alternative.